APPLICATION FOR NURSING HOME ADMISSION

Date: _____

Last Name: _____ First: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Age: _____ Date of Birth: _____ Place of Birth: _____

US Citizen: Yes ☐ No ☐ Sex: _____ Religion: _____ Does the applicant smoke? Yes ☐ No ☐

Are you a Veteran or Spouse of a Veteran? Yes ☐ No ☐ (If Yes, you may be entitled to benefits.)

Person Representing Patient

Name: _____ Relationship: _____

Please check if applicable
Power of Attorney: ☐
Health Care Proxy: ☐
Guardian: ☐

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Applicant's Marital Status

Single: ☐ Married: ☐ Widowed: ☐ Divorced: ☐ Separated: ☐

Spouse's Name: _____ Telephone Number: _____

Primary Care Physician: _____

Financial Disclosure

	Monthly Amount
Social Security	$ _____
Retirement Pension	$ _____
Veterans Pension	$ _____
SSI	$ _____
Other Income	$ _____

Finances/Resources/Insurances
(Please complete all that apply)

PRIVATE RESOURCES

Pensions $ _____ Source: _____

Savings $ _____ Certificate of Deposits $ _____

Checking Accounts $ _____ Stocks/Bonds $ _____

Property $ _____ Where? _____

Rental Income $ _____ Where? _____

INSURANCES

Medicare Part A? Yes ☐ No ☐ Part A Number: _____

Medicare Part B?: Yes ☐ No ☐ Medicare Part D?: Yes ☐ No ☐ Plan Name: _____

Medicaid: _____ Number: _____ County: _____

Secondary: _____ Number: _____

Have you applied for Medicaid? _____ Date Applied: _____

Have you sold or transferred any real property or other assets (including money, stocks/bonds, CDs, etc.) within the last five (5) years? Yes ☐ No ☐
If yes please provide details: _____

Section 366.5 of the New York State Social Services Law, enacted in 1982, states that any transfers of assets or resources within a 60 month period prior to applying for Medicaid will be presumed to have been done for the purpose of qualifying for Medicaid, resulting in a being ineligible for Medicaid assistance.

Are you currently working with an attorney regarding placement/Medicaid eligibility? Yes ☐ No ☐
Name of Attorney: _____

General Information

Do you have a prepaid burial? _____ Funeral Home? _____

Education Level: _____ Can Patient read and write? _____

To the best of my knowledge all information contained herein is correct and valid.

Signature of Responsible Party: _____

The information provided shall remain confidential and shall be made available only to authorized hospital and nursing home personnel involved in the placement process and to any governmental officials authorized access by law to such records.

It is the policy of the facilities accessing this application to admit and treat all patients without regard to race, creed, color, place of birth, national origin, sex, sexual preference, marital status, disability, sponsorship, or source of payment.
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